TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Mikhail Fukshansky, M.D.

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-17-1426-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
January 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was billed per Medical Fee Guideline conversion factors as established in Rule 134.203 (c) (2). The DWC Conversion Ration and conversion factors for the date of service are utilized for this claim … Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another … [A]n examination was performed and documented as a Detailed Examination component and billed as 99204."

Amount in Dispute: $405.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding the A4215, supplies normally used to complete the nerve conduction studies should not be billed separately. No additional allowance is recommended. Regarding 99204, Documentation does not support the level billed. Provider must document all three of the following: Comprehensive history, comprehensive exam, and moderate complexity decision making. None of these is met … Fee Schedule states that the denial of disputed code A4556 is correct: … In accordance with the CMS Physician Fee Schedule rule for status code 'P', this service is not separately reimbursed when billed with other payable services."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2016	Evaluation & Management, new patient (99204)	$265.21	$0.00
August 30, 2016	Nerve Conduction Studies, 11-12 studies (95912)	$107.91	$107.91
August 30, 2016	Electrodes, per pair (A4556)	$16.90	$0.00
August 30, 2016	Needle, sterile, any size, each (A4215)	$15.00	$0.00
August 30, 2016	Needle Electromyography, each extremity (95886)	$0.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - B1 – (B12) Services not documented in patients' medical records.
   - P1 – (P12) Workers' compensation jurisdictional fee schedule adjustment.
   - 45
   - P5
   - 23 – (234) This procedure is not paid separately.

Issues

1. What are the services considered in this dispute?
2. What are the applicable rules for this dispute?
3. Is Old Republic Insurance Company's reason for denial of payment for procedure code 99204 supported?
4. Is Old Republic Insurance Company's reason for denial of payment for procedure code A4556 supported?
5. Is Old Republic Insurance Company's reason for denial of payment for procedure code A4215 supported?
6. Is Old Republic Insurance Company's reason for reduction of payment for procedure code 95912 supported?

Findings

1. Mikhail Fukshansky, M.D. included procedure codes 99204, 95912, A4556, A4215, and 95886 on the Medical Fee Dispute Resolution Request (DWC060). Dr. Fukshansky is seeking $0.00 for procedure codes 95886. Therefore, this service will not be considered in this dispute. Dr. Fukshansky is seeking $405.02 for procedure codes 99204, 95912, A4556, and A4215. These services will be reviewed in accordance with applicable rules and guidelines for this dispute.

2. Reimbursement for the disputed codes is subject to the fee guidelines for professional medical services found in 28 Texas Administrative Code §134.203(b)(1), which states, in pertinent part:

   > for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

3. Old Republic Insurance Company (Old Republic) denied disputed procedure code 99204 with claim adjustment reason codes 97 – "THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED." The division finds that procedure code 95912, billed by Dr. Fukshansky on the same date of service, has a global status of "XXX." Chapter I of the General Correct Coding Policies for *National Correct Coding Initiative Policy Manual for Medicare Services*, section D, effective January 1, 2016 states, in relevant part:

   > Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code … **With <u>most</u> "XXX" procedures, the physician may, however perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code** [emphasis added]**.** This E&M service may be related to the same diagnosis necessitating the performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. **Appending modifier 25 to a**

significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding [emphasis added].

Review of the submitted documentation does not find that Dr. Fukshansky appended modifier 25 to procedure code 99204 in the billing process, signifying that the service was a significant, separately identifiable evaluation and management service. Therefore, Old Republic's denial reasons are supported. Reimbursement for this service cannot be recommended.

4. Old Republic denied disputed procedure code A4556 with claim adjustment reason codes 23 – "THIS PROCEDURE IS NOT PAID SEPARATELY." The division finds that CPT Code A4556 is a Bundled/Excluded code, which means:

   > There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.--If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

   The Medicare Benefit Policy Manual, Chapter 15 §60.1 states, "Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." The electrodes are incident to the physician services furnished the same day, therefore, they are bundled in those services. Old Republic's denial reason is supported. Reimbursement for this service cannot be recommended.

5. Old Republic denied procedure code A4215 with claim adjustment reason code 97 – "THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED." Medicare policy finds that CPT Code A4215 has a status of Statutory Exclusion, which means,

   > These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule…

   The division concludes that Old Republic's denial reason is supported. Reimbursement for this service cannot be recommended.

6. Old Republic reduced reimbursement for procedure code 95912 with procedure codes B1 – "SERVICES NOT DOCUMENTED N PATIENTS' MEDICAL RECORDS." Procedure code 95912 is defined by the American Medical Association as "nerve conduction studies, 11-12 studies." Review of the submitted documentation supports that Dr. Fukshansky performed 12 nerve conduction studies. The division concludes that Old Republic's reduction for this reason is not supported. The maximum allowable reimbursement (MAR) is determined per 28 Texas Administrative Code §134.203(c), which states:

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. The division conversion factor for 2016 is $56.82.

For procedure code 95912 on August 30, 2016, the relative value (RVU) for work of 3.00 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 3.057. The practice expense (PE) RVU of 4.19 multiplied by the PE GPCI of 1.006 is 4.21514. The malpractice (MP) RVU of 0.16 multiplied by the MP GPCI of 0.955 is 0.1528. The sum of 7.42494 is multiplied by the division conversion factor of $56.82 for a MAR of $421.89.

Dr. Fukshansky billed a total of $420.02 for this service. This is the total reimbursement allowed. Old Republic reimbursed $312.11. An additional reimbursement of $107.91 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $107.91.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $107.91, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 17, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.